

Patient Registration Form

SURNAME:		TITLE: MR <input type="radio"/> MRS <input type="radio"/> MSTR <input type="radio"/> MS <input type="radio"/> DR <input type="radio"/>	
FIRST NAME:		DATE OF BIRTH:	
STREET ADDRESS:			
SUBURB:		POSTCODE:	
HOME PHONE:		WORK PHONE:	
MOBILE:		CONSENT TO RECEIVE SMS REMINDERS:	YES <input type="radio"/> NO <input type="radio"/>
		CONSENT TO LEAVE VOICE MESSAGES:	YES <input type="radio"/> NO <input type="radio"/>

OCCUPATION:

MEDICARE NO:	REF NO:	EXPIRY:
PENSION NUMBER:		EXPIRY:
DVA NO:	WHITE GOLD	EXPIRY:
HEALTH CARE CARD NO:		EXPIRY:

NEXT OF KIN:	RELATIONSHIP:	PHONE:
EMERGENCY CONTACT:	RELATIONSHIP:	PHONE:
NAME OF PERSON RESPONSIBLE FOR PAYMENT:		
DOB OF PERSON RESPONSIBLE FOR PAYMENT:		
MEDICARE CARD & REF NUMBER OF PERSON RESPONSIBLE FOR PAYMENT:		

Patient Background

To assist with health initiatives – Do you identify as belonging to any of the following groups:

Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander
 Nationality _____

Do you have any allergies or sensitivities to medications, dressings, food? Yes No

If yes, please specify: _____

I understand that Eleanor Clinic complies with the Privacy Act (1988) and as part of their privacy policy, they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Eleanor Clinic collecting, using, storing and disposing of my personal information, the release of relevant personal information to other health professionals to allow quality medical care, inclusion in a recall register to advise of follow up visits, inclusion in the reminder systems, medical updates and health information and the release of relevant information to my (prospective) employer, their authorised representative and their insurer in the case of a work related consultation or service. I understand I may withdraw my consent for Eleanor Clinic to use and disclose my personal information (except when legal obligations must be met).

Date:	Patient/Guardian Signature:
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ELEANOR CLINIC

Patient Medical Information

Patient Name: _____ DOB: _____

Address: _____

ALLERGIES:	<i>Please include medications, foods, tapes, etc..</i>
PAST MEDICAL HISTORY:	<i>Please include any previous illnesses, operations or procedures:</i>
FAMILY HISTORY:	<input type="radio"/> Diabetes <input type="radio"/> Heart Disease <input type="radio"/> Depression/Anxiety <input type="radio"/> Stroke <input type="radio"/> Asthma <input type="radio"/> Breast Cancer <input type="radio"/> Bowel Cancer <input type="radio"/> Other type of cancer <input type="radio"/> High Blood Pressure <i>Please list family member/s affected:</i>
CURRENT MEDICATION:	<i>Please include over the counter medications, this includes Panadol, Nurofen or any other pain medication, puffers, sprays & any natural remedies)</i>
SMOKER:	<input type="radio"/> Yes. If so, how many cigs per day _____ <input type="radio"/> No <input type="radio"/> Ex-Smoker and if so what year finished smoking _____
ALCOHOL:	<input type="radio"/> No <input type="radio"/> Yes Drinks per day? _____ Days per week? _____
WOMEN ONLY:	Date of last Cervical Screen (Pap Smear): _____ If over 50: <input type="radio"/> Bowel Screen (Year _____)
MEN ONLY:	Family history of <input type="radio"/> Prostate Cancer <input type="radio"/> Breast Cancer <input type="radio"/> Bowel Cancer <input type="radio"/> Depression If over 50: <input type="radio"/> Bowel Screen (Year)
EXERCISE:	Type: _____ How Often: _____

Do you have anything else you would like to share with us that would help us look after you?
